



Fermilab

Fermi National Accelerator Laboratory
P.O.Box 500 • Batavia, Illinois • 60510

Coverage Change Request

_____ requests a change to :
(Employee Name)

- ☐ Medical and/or dental coverage
- ☐ Health Care Reimbursement Account
- ☐ Dependent Care Reimbursement Account

I certify that I am making the change based on the status change as indicated and that I am making this change within the allowable 30-day period. Your election change must be consistent with the change in your status. Date status change occurred: _____

- ☐ Change in legal status, including marriage, death of spouse, divorce, legal separation or annulment.
- ☐ Change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent.
- ☐ Change in employment status, including termination or commencement of employment of the employee, spouse or dependent and including a switch from salaried to hourly paid status as well as from hourly paid to salaried.
- ☐ Change in work schedule, including an increase or decrease in the number of hours of employment by the employee, spouse or dependent, including a switch between full-time and part-time status, a strike or lockout, or commencement or return from an unpaid leave of absence.
- ☐ The dependent satisfies or ceases to satisfy the requirements for unmarried dependents. An event that causes an employee's dependent to satisfy the requirements for coverage due to attainment of age, student status or any similar circumstances as provided under the health plan under which the employee receives coverage.
- ☐ A change in the place of residence or work site of the employee, spouse or dependent.
- ☐ A significant change in the health coverage of the employee or spouse attributable to the spouse's employment (e.g. loss of coverage, change of plan, increase or decrease of premium by 20% or more).

I certify that the above information is correct.

Employee Signature _____ **ID** _____

Date _____